FIRST BENEFIT ADMINISTRATORS

HRA Enrollment Form

Employer To Complete Section	
Plan Year:	☐ 12 Month Plan Year ☐ Short Plan Year
Employer Name:	
Employee Effective Date:	*Month/date/year:*
Department / Location	
Employee Name (First & Last Name)	
Social Security Number	
Date of Birth	
Daytime Phone Number ☐ *check if phone number has changed*	
Address: ☐ *check if address has changed*	Street: City: State: Zip:
Email	

HEALTH REIMBURSEMENT ACCOUNT TOTAL $ _____

☐ **YES, I WANT TO ENROLL IN THE HRA**

The IRS regulations states four conditions:

1. Any expense you incur must be within the plan year.
2. Any expenses incurred must not be covered by any other sources such as insurance.
3. You must provide proper documentation in order to receive payment
4. You cannot change or revoke your election during the plan year unless there is a specific change of status and your employer allows such changes

☐ **NO, I DO NOT WANT TO ENROLL IN THE HRA**

If a change of status occurs, I may have the right to enroll in the plan at that time if my employer's plan allows.

Signature: **Date:**

Mail Completed Forms to:

FIRST BENEFIT ADMINISTRATORS, INC
9455 Koger Blvd. N. Suite 100
St. Petersburg, FL 33702
Phone: 727.530.4144 ◊ Fax: 727.532.9602
www.firstbenefitadmin.com